

## ANOTHER LOOK AT THE *MORBUS GALLICUS*\*

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BY

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A crystal clear, sunny evening for the Society's reception, on the top floor of the World Health Organization building in Geneva, made a setting of perfection. On one side was Lake Léman and the low green hills beyond; on the other, a breath-taking view of Mont Blanc in all its grandeur. I was not alone in feeling, that there in the heart of Europe, one might climb the highest of Alpine mountains to survey the whole Continent. But purely geographical survey would hardly suffice; to me it could only be alive in history and there seemed no better vantage point, than here in Switzerland to mull over the origins and early history of Europe's medieval epidemic of the *Morbus Gallicus*.

The old terminology is used, in preference to "syphilis", since descriptions under the old title are so different from the venereal disease as we know it to-day and as it has been clearly recognized for 300 years.

Thomas Sydenham in 1679 (Latham, 1850) was probably the first to point out this distinction. He saw cases of active early yaws in England and noted the resemblance of this disease to the old descriptions of *Morbus Gallicus*. He concluded that that disease had "changed its form from its first appearance as a disease of contagion, to my time when it has become a venereal disease". Sydenham was the first to suggest that the *Morbus Gallicus* was not the same as syphilis but had been imported into Europe from Africa. This was no passing thought on the part of Sydenham; he had collected information from travellers to the Caribbean and described the disease there as:

"brought from Guinea by slaves who laboured under it without any impure coition. Frequently enough a whole family, men, women, and children, suffer from it at the same time. Nor does this disease differ in the least from syphilis, if we make allowances for the climate. It has another name, being called the yaws".

Sydenham was doubtless aware of the writings of his time which described the disease in Africa; of Cleyer's description of it from Java in 1681; and of James Bontius's from the Malacca Islands telling of a disease in the natives with signs "resembling the venereal but with this difference, that here they are liable to it without the use of venery". In these several descriptions the highly contagious nature of the infection is noted.

Hudson (1964), giving support to the unitarian view of treponemal diseases, believes that all these infections are one and the same disease spreading out over the world from Africa over the past few thousand years and being altered in appearance by climate and customs. He sees the original disease as yaws modified first to endemic syphilis by cooler and drier climates and finally metamorphosed to venereal syphilis with the added effects of clothing and higher standards of hygiene. Hudson gives clear evidence that both the Portuguese and Spanish shipped slaves from West Africa for half a century before Columbus's voyage of discovery in 1492; such slave-trading would import yaws. There is evidence from Hudson also that slave traffic overland to Portugal and Spain took place even before the first shipment in 1442; slave trains would import endemic syphilis. No one is in any doubt that later the slave trade to the Caribbean established yaws in that area. Hudson believes that in spite of quarantine arrangements treponemal disease was established in the Iberian peninsula before the return of Columbus in March, 1493. He believes this to have been the source of the epidemic and finds it laughable that anyone should believe that 44 crew members and the ten West Indians who returned with Columbus could account for the scourge present throughout the Continent within so few years.

There seems to be one stumbling block to full acceptance of this theory. Unless we assume some mutation of the treponeme or find some host

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deficiency in Europeans, then the late complications and the congenital manifestations of syphilis, so conspicuously absent in non-venereal forms of treponemal disease, remain to be explained.

To-day the Columbian theory is the most favoured explanation of the origin of syphilis—and not without good reason. Many efforts have been made to prove that syphilis or something akin to it existed in the Old World before the return of Columbus, but none have met with success. The writings of Karl Sudhoff (1917–22) on this subject have generated more heat than conviction. Others have sought evidence in the Bible, suggesting that the death of 24,000 worshippers of Baal Peor after whoredom with the daughters of Moab was due to syphilis; the *Botch* of Egypt, described in Deuteronomy, has also been attributed to syphilis. Neither of these theories has met with credence. Claims that human bones dating from the days of ancient Egypt showed evidence of syphilis are discounted by the studies of Elliot Smith (1907, 1908) who examined some 24,000 mummies and found no evidence of the disease. The paucity of signs suspicious of syphilis in pre-Columbian bones in Europe is equally striking. Likewise claims regarding syphilis in Ancient Greece and Rome, in China, and in India are considered by even the most credulous historians to be at best inconclusive.

All this is negative, but the Columbian theory is positively supported by well-documented evidence. The most vital of this comes principally from two Spanish physicians who lived at the time of Columbus. One, Fernandez ab Oviedo was closely connected with the Spanish court, and was in Barcelona at the time of Columbus's return from the first voyage. He was acquainted with members of the crew. Later he was sent by King Ferdinand of Spain to superintend the gold and silver mines at Darien. In his book, dated 1525, he confirmed that the disease which he saw for the first time in Europe, was native to the islands of Hispaniola although its course in the inhabitants was milder than in Europeans. It had long been known in the New World where elaborate treatment regimes were recognized.

Even more convincing are the contemporary records of the second physician, Ruy Dias de Isla, who was also in Barcelona when Columbus returned in 1493. He described syphilis as "a disease previously unknown, unseen and undescribed which first appeared in Barcelona". His book "A Treatise on the Serpentine Malady" was written between 1510 and 1520 after he had returned to his native Lisbon.

Something of the books of these two physicians had been known for a long time. We are indebted

however to Montejó y Robledo, a Spanish army surgeon, who in 1882 reported his review of *all* the early Spanish writings on syphilis. He made an extensive collection of his authorities, collated them carefully, and examined them critically. He not only included a detailed survey of de Isla's book but, in the National Library of Madrid, found de Isla's original manuscript which included paragraphs not in the printed text: for instance, a statement that Columbus's pilot, Pinzon of Palos, had the new disease on his return and that he treated Pinzon as well as other members of the crew for it.

Both Oviedo and de Isla were in no doubt that the new disease, once arrived in Europe, spread rapidly over the continent. In this they are in accord with their contemporary writers. The Columbian theory of origin is further favoured by the discovery, in allegedly pre-Columbian graves in North and South America, of skulls and long bones showing changes compatible with syphilitic osteitis and periostitis.

Both theories, unitarian and Columbian, so briefly summarized here, have much conviction in them and it is little wonder that controversy continues. One thing however, is certain. The sudden transformation in the Old World medical literature between 1495 and 1498 bears ample testimony to the sudden and terrifying diffusion which the new disease achieved. Of all the names given to it *Morbus Gallicus* proved the most lasting.

The question which now arises is whether sufficient thought has been given to accepting both origins. In other words, is it possible that *Morbus Gallicus* was in fact two diseases existing side-by-side and undifferentiated? Some support for this suggestion is given by three pieces of evidence:

(1) There is the important study by Astruc (1754) who collected and organized all the many clinical descriptions then available. His most important observation was that the *Morbus Gallicus* waned steadily in severity over more than a century. He was able to describe this metamorphosis to syphilis as Sydenham saw it and as we see it, in five periods:

(i) The disease was noted as starting with genital ulcers, 1, 2, or even 4 months after contact. The ulceration is always mentioned in the plural. Such a beginning was noted by Antonio Scanoroli to be the case in old men or young virgins. Montesauro saw cases without genital lesions and Widman and Leonicerio both noted oral lesions as a common beginning. All these writers are mentioned by Sudhoff and Singer (1925). The oral affections are picturesquely described by Astruc—"When the disease attacked the head, chiefly it produced acrid

rheums which eroded sometimes the palate, sometimes the uvula, sometimes the jaws and tonsil”.

(ii) Whatever the beginnings, a widespread pleomorphic rash followed and many of the lesions became phagedenic or pustular. Gummy tumours which frequently grew to the “size of an egg” commonly deformed the legs and pain in the limbs due to periostitis and osteitis was frequent; later, fever, general deterioration, and emaciation led to death. Children were noted as liable to the infection and many adults claimed to have acquired the disease other than sexually. This was the picture at the peak of virulence by the year 1516 and so far all this has the familiar ring of descriptions of treponemal diseases other than syphilis.

(iii) From 1526 to 1540 the disease showed abatement of severity; few papules were noted in affected individuals whilst inguinal adenitis and alopecia were commoner features. Bone pains were less severe and much less frequent.

(iv) From about 1540 to 1550, there was a further diminution of all signs and symptoms, but the urethral discharge of gonorrhoea seems to have been so commonly associated as to be part of the accepted clinical picture.

(v) The final period ended in 1610, by which time only one new and occasional symptom had been added, namely “noises in the head”.

One cannot escape noticing how the earliest descriptions of *Morbus Gallicus* so closely resemble those of yaws or bejel or other extant forms of endemic treponematoses. Is it not just possible that *Morbus Gallicus* was really two treponemal diseases, the less common venereal form being masked by the more highly contagious, more florid, endemic form? With the spread of Renaissance influences in Europe this latter came under control within little more than 100 years, its virtual eradication leaving us with syphilis.

(2) A second support to the argument is the late arrival on the scene of associated gonorrhoea. Long before the time of Columbus, this disease had been recognized as a separate entity and its sexual transmissibility was widely accepted. In 1527, Bethencourt claimed it as part of the symptomatology of *Morbus Gallicus*. Paracelsus concurred in 1536. Ambroise Paré and Sydenham both accepted the idea without question. Thus, physicians came to talk and write of “the venereal disease” and the term “lues venerea” or more simply “the venereal” became common coin.

If such confusion of two very dissimilar diseases, gonorrhoea and syphilis, could arise, how much

more easily should there have been confusion between venereal and non-venereal forms of treponematoses.

(3) The third supporting piece of evidence comes from clinical descriptions appearing in the late 17th, the 18th, and the early 19th centuries. Each of the descriptions referred to is of a contagious disease resembling the *Morbus Gallicus*. There is the “radesqye” of the west coast of Norway, the “saltglurr” of Sweden, the “dithmarsh evil” of Jutland and Schleswig-Holstein, the “spirocolan” of Greece, the non-venereal syphilis of Bosnia, the “pian” of Nérac in France, the “button scurvey” of Ireland and the “sibbens” of Scotland.

The reports of these diseases have many facets of epidemiological and clinical description in common. All note that rural peoples—men, women, and children—living in poor or primitive surroundings were affected. All the conditions were, like *Morbus Gallicus*, highly contagious at the social rather than the sexual level of intercourse. Like the *Morbus Gallicus* their rapid dissemination struck terror into the hearts of the people. Early oral lesions were common and were followed by rashes and the nocturnal bone pains of periostitis. The resemblances to syphilis and to yaws were recognized by several physicians.

Not least of the vital points in these old records is that frequently the venereal and non-venereal forms of treponemal diseases existed side-by-side within the boundaries of a single country. The non-venereal form was found in the rural or more isolated areas and the venereal form in the towns. The need for differential diagnosis was recognized.

You may think therefore, as I do, that there is some support for a theory which embraces both the unitarian and Columbian views of the origin and early history of the European disease we have come to know as venereal syphilis. That is, by the end of the 15th century two diseases had arrived in Europe—yaws or endemic syphilis from West Africa and venereal syphilis from America. With the spread of Renaissance influences of education, sophistication in dress, and improved personal hygiene, the complex known so widely as *Morbus Gallicus* faded from central Europe. Residua were found only in the most backward areas, causing sporadic outbreaks. It is of some interest to note that all the European non-venereal forms mentioned survived only on the fringe of the continent; there the late arrival of learning determined their eventual eradication. Venereal syphilis, unmasked, remained and remains to this day clinically unchanged.

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